Client Assistance Program
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The Consumer Checklist for the Division of Vocational Rehabilitation
Order of Selection Waiting List

Division of Vocational Rehabilitation (DVR) Consumers and counselors may use this optional form as a tool for discussing how an individual's disability or disabilities limits their ability to find, keep or advance in a job.

A.	**MOBILITY LIMITATIONS**		
A1.	Are you limited in speed or distance when walking?	Yes	No
A2.	Do you required assistance from either a person or a device to walk and/or drive a vehicle?	Yes	No
A3.	Is the ability to drive affected by your disability?	Yes	No
A4.	Do you require mobility training or help from others in order to get around in the community?	Yes	No
B.	**COMMUNICATIONS LIMITATIONS**		
B1.	Is your speech difficult to understand?	Yes	No
B2.	Do you need another means of communication such as sign language, lip reading, braille, enlarged print, or a speech board?	Yes	No
B3.	Do you have difficulty explaining your needs?	Yes	No
B4.	Is it difficult for you to understand what you are reading or to express yourself in writing?	Yes	No
C.	**SELF-CARE LIMITATIONS**		
C1.	Do you have difficulty with grooming, hygiene, or dressing yourself?	Yes	No
C2.	Do you have problems cooking, shopping, or doing other household chores by yourself?	Yes	No
C3.	Do you need help managing your money or managing your time?	Yes	No
D.	**SELF-DIRECTION LIMITATIONS**		
D1.	Have family, friends, or health care professionals criticized your decisions?	Yes	No
D2.	Have you ever been hospitalized to prevent you from hurting yourself or others?	Yes	No
D3.	Do you have difficulty following through on things?	Yes	No
D4.	Do you have difficulty controlling your own behavior?	Yes	No
E.	**LIMITATIONS IN INTERPERSONAL SKILLS OR ACCEPTANCE**		

E1.	Do you feel uncomfortable around other people?	Yes	No
E2.	Do you become angry or frustrated easily?	Yes	No
E3.	Have you been asked not to return to a place because of your behavior?	Yes	No
E4.	Does your disability affect your actions in a way that might be difficult for others to understand?	Yes	No
E5.	Does your disability affect your appearance in a way that others may not understand or accept?	Yes	No

F. WORK TOLERANCE LIMITATIONS

F1.	Do you have any restrictions in standing, sitting, bending, lifting, or repetitive motion?	Yes	No
F2.	Do you have any restrictions that require frequent rest periods or a flexible work schedule?	Yes	No
F3.	Are you restricted from working full time?	Yes	No
F4.	Do you require a low stress job with limited responsibilities?	Yes	No

G. WORK SKILLS LIMITATIONS

G1.	Does your disability prevent you from using your work skills or training?	Yes	No
G2.	Do you feel your work skills are outdated because your disability has kept you out of the workforce?	Yes	No
G3.	Do you need an accommodation to perform the jobs you qualify for?	Yes	No

After reviewing the questions above, are there work related areas below that are <u>significantly</u> limited by the disability or disabilities?

____ Mobility
____ Communication
____ Self-Care
____ Self-Direction
____ Interpersonal Skills
____ Work Tolerance
____ Work Skills

Source: Title 34 Code of Federal Regulation: Education
PART 361—STATE VOCATIONAL REHABILITATION SERVICES PROGRAM §361.5 Applicable definitions. (30) Individual with a significant disability means an individual with a disability—
(i) Who has a severe physical or mental impairment that seriously limits one or more functional capacities (such as mobility, communication, self-care, self-direction, interpersonal skills, work tolerance, or work skills) in terms of an employment outcome.